# Care Coordination Services
# Conditions of Participation

*Care coordination services are provided for every recipient. Care coordinators assist individuals to gain access to waiver and other state plan services, as well as medical, social, educational, and other services with funding sources other than Medicaid. For recipients, care coordinators manage the process of planning for services, developing a plan of care, on-going monitoring of services, and renewing the plan of care annually. Throughout the year, care coordinators remain in contact with recipients in a manner, and with a frequency, appropriate to the needs of the recipients.*

*The provider who chooses to offer care coordination services must be certified as a provider of care coordination services under 7 AAC 130.220 (b)(2), meet with the requirements of 7 AAC 130.240, and operate in compliance with the following standards.*

## I. Program Administration

A. **Personnel**.

1. Care coordination services program administrator.
   a. The provider must designate a care coordination services program administrator who is responsible for the day-to-day management of the program including the following:
      i. orientation, training, and supervision of care coordinators;
      ii. implementation of policies and procedures;
      iii. intake processing and evaluation of new admissions to the services;
      iv. participation in the development of plans of care in collaboration with other providers of services;
      v. ongoing review of the delivery of services, including
         (A) monitoring the amount, duration, and scope of services to assure delivery as outlined in the plan of care;
         (B) assessing whether the services assist the recipients to attain the goals outlined in plans of care; and
         (C) evaluating the quality of care rendered;
      vi. development and implementation of corrective action plans for identified problems or deficiencies in delivery of care coordination services; and
      vii. submission of required reports to Senior and Disabilities Services, including critical incident reports.
   b. The provider may use a term other than program administrator for this position, e.g., program director, program manager, or program supervisor.
   c. The program administrator must be at least 21 years of age, and qualified through experience and education in a human services field or setting.
      i. Required experience:
         (A) one year of full-time or equivalent part-time experience working with human services recipients and their families, programs and grants administered by Senior and Disabilities Services, and providers of program and grant services; and
         (B) one year (which may be concurrent) of full-time or equivalent part-time experience, as a supervisor of two or more staff who worked full-time or equivalent part-time in a human services field or setting, in a position with responsibility for planning, development, and management or operation of programs involving service delivery, fiscal management, needs assessment, program evaluation, and similar tasks.

ii. Required education and additional experience or alternatives to formal education:
(A) Bachelor of Arts or Bachelor of Science degree from an accredited college or university in social work, psychology, rehabilitation, nursing or a closely related human services field, in addition to the required one year of experience as a supervisor; or
(B) Associate of Arts degree from an accredited college or university in psychology, rehabilitation, nursing or a closely related human services field, and two years of full-time or equivalent part-time experience working with human services recipients, in addition to the required one year of experience as a supervisor; or
(C) four years of full-time or equivalent part-time experience working with human services recipients in social work, psychology, rehabilitation, nursing, or a closely related human services field or setting, in addition to the required one year of experience as a supervisor; or
(D) certification as a rural community health aide or practitioner, and one year of full-time or equivalent part-time experience working with human services recipients, in addition to the required one year of experience as a supervisor.

c. In addition to meeting education and experience requirements, the administrator must possess the knowledge base and skills necessary to carry out the care coordination services program.
i. The administrator knowledge base must include:
(A) the medical, behavioral, habilitative, and rehabilitative conditions and requirements of the population to be served; and
(B) the applicable laws and policies related to Senior and Disabilities Services programs.
ii. The administrator skill set must include:
(A) the ability to evaluate, and to develop a plan of care to meet, the needs of the population to be served; and
(B) the ability to supervise professional and support services staff.

2. **Care coordinators.**
a. Care coordinators shall be at least 18 years of age, and qualified through experience and education in a human services field or setting.
b. Required education and additional experience or alternatives to formal education.
i. Bachelor of Arts , Bachelor of Science, or Associate of Arts degree from an accredited college or university in social work, psychology, rehabilitation, nursing or a closely related human services field, and one year of full-time, or equivalent part-time experience working with human services recipients; or
ii. two years of course credits from an accredited college or university in social work, psychology, rehabilitation, nursing or a closely related human services field, and one year of full-time, or equivalent part-time experience working with human services recipients; or
iii. three years of full-time or equivalent part-time experience working with human services recipients in social work, psychology, rehabilitation, nursing, or a closely related human services field or setting; or
iv. certification as a rural community health aide or practitioner and one year of full-time or equivalent part-time experience working with human services recipients.
c. In addition to meeting education and experience requirements, care coordinators must possess, or develop before providing program services, the knowledge base and skills necessary to carry out the care coordination process.
i. The care coordination knowledge base must include:
(A) the medical, behavioral, habilitative, and rehabilitative conditions and requirements of the population to be served by the care coordinator;
(B) the laws and policies related to Senior and Disabilities Services programs;
(C) the terminology commonly used in human services fields or settings;
(D) the elements of the care coordination process; and
(E) the resources available to meet the needs of recipients.

ii. The care coordination skill set must include:
(A) the ability to evaluate, and to develop a plan of care to meet, the needs of the population to be served;
(B) the ability to organize, evaluate, and present information orally and in writing; and
(C) the ability to work with professional and support staff.

B. **Training**.

1. An individual who seeks certification to provide care coordination services
   a. must enroll in the Senior and Disabilities Services basic training course;
   b. demonstrate comprehension of course content through examination; and
   c. provide proof of successful completion of the course when submitting an application for certification.
2. A certified care coordinator
   a. must enroll in at least one Senior and Disabilities Services care coordination training course during the individual's one or two year period of certification; and
   b. provide proof of successful completion of that course when submitting an application for recertification.

## II. Program operations

A. **Quality management**.

1. Plan of care tracking system.
   a. The provider must develop a system to monitor plan of care development and implementation to ensure that plans of care for recipients
      i. are complete and submitted within required timeframes;
      ii. address all needs identified in the recipient's assessment;
      iii. include the personal goals of the recipient; and
      iv. address recipient health, safety, and welfare.
   b. The provider must develop and implement
      i. a protocol for analysis, annually at a minimum, of the data collected through its tracking system;
      ii. a procedure for correcting problems uncovered by the analysis;
      iii. a process for summarizing the annual analysis and corrective actions for inclusion in a report to be submitted to Senior and Disabilities Services with the provider's application for recertification or to be made available upon request.
   c. At a minimum, the provider must determine whether
      i. services meet the needs of the recipients;
      ii. services are effectively coordinated among the various providers;
      iii. recipients and their informal supports are encouraged to participate in the care coordination process;
      iv. recipients are afforded the right to make choices regarding their care; and
      v. services are integrated with informal care and supports.

B. **Backup care coordinator**.

1. The provider must designate, for each care coordinator, another care coordinator to serve as backup when the primary care coordinator will not be available to provide services.
2. The backup care coordinator may provide services to no more than the number of recipients, including that of the primary care coordinator's usual case load, for which service coordination, as well as response to any emergency, can be managed effectively.
3. The provider must inform each recipient, affected by the end of the provider's association with a care coordinator employee, of the name and contact information for a care coordinator who will serve as backup until the recipient chooses another care coordinator to provide services. .

C. **Billing for services**.

1. The provider may not submit a claim for reimbursement for care coordination services until the services have been rendered.
2. Claims for monthly care coordination services for recipients may not be submitted until the first day of the month following the month in which services were rendered.

## III. Recipient relationships.

A. **Conflicts of interest**.

1. The care coordinator must
   a. afford to the recipient the right to choose to receive services from any certified provider;
   b. inform the recipient of any employment relationship or any other relationship with other provider personnel or owners if he/she plans to recommend services from that provider; and
   c. facilitate the transfer process when the recipient chooses to receive care coordination services from another care coordinator.
2. The care coordinator may not offer, promote, or sell products or non-program services to, or engage in any commercial transaction with, recipients, their families, or their representatives without the written consent of Senior and Disabilities Services.
3. The provider must develops a process for resolution of conflicts that might arise between the care coordinator and the recipient, family, or informal supports, regarding needs, goals, or appropriate services.

B. **Recipient contacts**.

1. The care coordinator must meet in-person with the recipient at least once in each service environment during the plan year.
2. During each in-person meeting, the care coordinator must address the following topics with the recipient or the recipient's representative:
   a. whether services have been delivered in the scope, duration, and frequency described in the plan care;
   b. whether the delivery of services was acceptable in terms of safety and respect for the recipient; and
   c. whether adjustments to the plan of care or to arrangements with providers might be needed because of changes in the recipient's health or other circumstances.
3. The care coordinator must document the content of each contact with the recipient, and the method used to make that contact.
   a. The record of each in-person contact must be signed by the recipient or the recipient's representative.
   b. If the recipient is unable or unwilling to sign the record, the care coordinator
      i. must indicate the cause of the inability or unwillingness to sign, and
      ii. may request other providers who are present at the time to sign the record.

## IV. The care coordination process.

A. **Care coordination goals.**

The provider must operate its care coordination services program for the following purposes:

1. to foster the greatest amount of independence for the recipient;
2. to enable the recipient to remain in most appropriate environment in the home or community;
3. to build and strengthen family and community supports;
4. to treat recipients with dignity and respect in the provision of services;
5. to secure for recipients appropriate, comprehensive, and coordinated services that will promote rehabilitation and maintenance of current abilities;
6. to serve as a link to increase access to community-based services; and
7. to improve the availability and quality of services.

B. **Plan of care development**.

1. Recipient orientation. The care coordinator must
   a. orient the recipient, and the recipient's family, and informal supports to the care coordination process;
   b. provide information about service options for medical, social, educational, and other services;
   c. affirm the recipient's right to choose to receive services from any qualified provider; and
   d. offer assistance in identifying potential providers for the recipient.

2. Planning team. The care coordinator must identify, and consult with each member of, a planning team for the purposes of
   a. developing an individualized, person-centered plan of care that identifies problems and strengths, and focuses on understanding needs in the context of the recipient's strengths; and
   b. providing an opportunity for the recipient and family
      i. to express outcomes they wish to achieve,
      ii. to request services that meet identified needs, and
      iii. to explain how they would prefer that the services to be delivered.
3. Integrated program of services. The planning team must
   a. incorporate the findings of the most recent evaluation or assessment in the plan of care;
   b. recommend services that support and enhance, but do not replace unless necessary, care and support provided by family and other informal supports;
   c develop an integrated program of individually-designed activities, experiences, services, or therapies needed to achieve identified, expected outcomes or goals and objectives; and
   d. write a plan of care that meets program requirements, and that specifies the responsibilities of the care coordinator, the recipient, and the recipient's informal and formal supports.
4. The care coordinator must deliver copies of the plan of care to all providers of services included in the plan of care.

C. **Plan of care implementation**.

The care coordinator must

1. arrange for the services and supports outlined in the plan of care, and coordinate the delivery of the services on behalf of the recipient;
2. support the recipient's independence by encouraging the recipient, family, and informal supports to be responsible for care to the greatest extent possible; and
3. teach the recipient and family how to evaluate the quality and appropriateness of services.

D. **Service monitoring**.

1. The care coordinator must contact the recipient at least twice a month, and as frequently as necessary, to evaluate whether the following conditions are met.
   a. The services are furnished in accordance with the plan of care and in a timely manner.
   b. The services are delivered in a manner that protects the recipient's health, safety, and welfare.
   c. The services are adequate to meet the recipient's identified needs.
2. The care coordinator must evaluate whether changes in the needs or status of the recipient require adjustments to the plan of care or to arrangements with providers.
3. The care coordinator must contact each provider of services for a recipient
   a. every three months, at a minimum, to verify service utilization in the amount, duration, and frequency specified in the plan of care; and
   b. as needed to
      i. ensure coordination in the delivery of multiple services by all providers,
      ii. address problems in service provision or goal achievement,
      iii. consult regarding need to alter plan of cares, and
      iv. intervene to make providers more responsive to the recipient's needs.
4. The care coordinator must act to ensure substandard care is improved or arranges for service delivery from other providers.
5. The care coordinator must notify, within five business days, any provider affected by a recipient's termination of a service or move to another residence.

E. **Care coordinator appointment and transfer**.

1. The care coordinator must notify Senior and Disabilities Services, on a form provided by Senior and Disabilities Services, of
   a. the care coordinator's appointment when selected by a recipient to provide services; and
   b. the transfer of care coordination services to another care coordinator.
2. The care coordinator must send to the new care coordinator, within 5 working days of notice of appointment of that care coordinator, the following materials:
   a. current plan of care and amendments to the plan,
   b. most recent assessment,
   c. case note for the past 12 months, and
   d. additional documents or information necessary for a safe transition.
3. The former and the new care coordinators must cooperate to ensure that all services outlined in the recipient's plan of care continue during a transfer of care coordination services.
4. The newly appointed care coordinator must send a copy of the appointment form to all providers listed in the plan of care to notify them of the change in care coordination services.